**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
SurgInsite Southeast Texas

**Respondent Name**
Tower National Insurance Co

**MFDR Tracking Number**
M4-13-1406-01

**Carrier's Austin Representative**
Box Number 17

**MFDR Date Received**
February 5, 2013

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Enclosed is Attachment accompanied by supporting documentation."

**Amount in Dispute:** $8,354.24

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Requestor in this matter request 100% of billed charges for two separate injection procedures performed in an office setting. However, the fee guidelines do not allow for 100% of billed charges. Requestor in this matter has been paid pursuant to the fee guidelines for the service billed. No additional reimbursement should be allowed. "

**Response Submitted by:** Downs Stanford PC

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| December 11, 2012<br>December 18, 2012 | 64640 | $8,354.24 | $413.06 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 59 – Processed based on multiple or concurrent procedure rules

**Issues**

1. Did the respondent support reduction of disputed services?
2. Is the requestor entitled to reimbursement?

**Findings**

1. 28 Texas Administrative Code §134.203 (c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service conversion factor). For Surgery when performed in a facility setting, the established conversion factor to be applied is(date of service conversion factor), For services in 2012 the maximum allowable reimbursement or MAR = (TDI-DWC Conversion Factor / Medicare Conversion Factor ) x Non-Facility Price or (68.88 / 34.0376) x $220.35 = $445.91.

| Date of Service | Submitted Charge | MAR | Amount Paid | Amount due |
|---|---|---|---|---|
| December 11, 2012 | $2.088.56 | (68.88 / 34.0376) x $220.35 = $445.91 | $272.01 | $173.90 |
| December 11, 2012 | $2.088.56 | (68.88 / 34.0376) x $110.18 (procedure subject to multiple procedure 50% reduction) = $222.97 | $136.01 | $86.96 |
| December 18, 2012 | $2.088.56 | (68.88 / 34.0376) x $220.35 = $445.91 | $344.45 | $101.46 |
| December 18, 2012 | $2.088.56 | (68.88 / 34.0376) x $110.18 (procedure subject to multiple procedure 50% reduction) = $222.97 | $172.23 | $50.74 |
| Total | $8,354.24 | $1,337.76 | $924.70 | 413.06 |

2. The total allowable reimbursement for the services in dispute is $1,337.76. This amount less the amount previously paid by the insurance carrier of $924.70 leaves an amount due to the requestor of $413.06. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $413.06.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $413.06 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | August , 2014<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.